E X C E L H E A L T H C A R E S E R V I C E S

Physician's Statement

This form must be completed by a physician, physician assistant, or nurse practitioner.

Personal Data

Name_____ Social Security Number_____

Address_____

City_____ State_____ Zip Code_____

Phone_____Cell_____

Medical Release Authorization

I _____ do hereby authorize_____ to
Patient Name *Physician Name*
release any information acquired during medical examination, relevant to employment with Excel Healthcare Services.

Immunization Records **Excel Healthcare Services must receive a copy of the results of all vaccinations, and or chest x-ray reports (if applicable) before employee is hired for the purpose of home health staffing. Vaccination dates, not titers, are required for home health staffing only.**

	Date	Results	Immune
Hepatitis Vaccine 1	_____		
Hepatitis Vaccine 2	_____		
Hepatitis Vaccine 3	_____		
Polio Vaccine	_____		
MMR Vaccine	_____		
Diptheria-Tetanus (DT) Vaccine	_____	*(required every 10 years)*	
T.B. Skin Test (PPD)	_____	Neg.☐ Pos.☐	_____MM
Chest X-ray (only if PPD pos.)	_____		
BCG Vaccine	_____	Yes ☐ No ☐	

(vaccine given in foreign countries for TB, not given in USA)

Physical Examination

Temp _____ Pulse _____ Respirations _____ Blood Pressure _____

The above named patient has been examined by me and found to be in good physical and mental health, free of communicable disease and able to function without any physical limitations or weight lifting restrictions as a healthcare professional.

Physician Name (please print)_____ License Number_____

Physician Address_____

City/State/Zip Code_____ Phone_____

Physician Signature_____ Date_____